

The Psychiatric Bulletin

FOR THE PHYSICIAN IN GENERAL PRACTICE



SUMMER, 1951

ENURESIS—PAGE 54

THE *Psychiatric* BULLETIN

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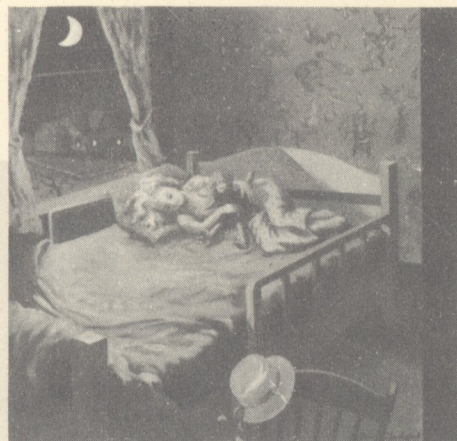
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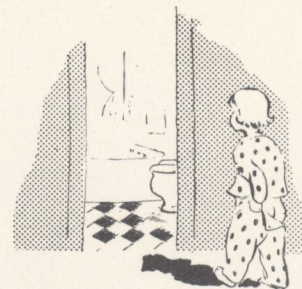
THE COVER

Bed-wetting is an annoying problem to both parents and children. Although occasionally there is some physical cause for it, usually a child wets the bed because he feels emotionally insecure or is under excessive tension. His parents may not realize this, and in their efforts to correct the problem of enuresis, may make it even worse by scolding, shaming or bribing the child. Most children will not become bed-wetters if they are allowed to achieve bladder control at the time when their bodies are ready for it and if they can live in an atmosphere where they feel secure and are not constantly uneasy and under tension. A more complete discussion of the problem may be found on page 54.

The painting on the cover was executed by Mr. George Shackelford.

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#hypochondriasis

THE PHYSICIAN attempting to treat the hypochondriacal patient with pills, powders and potions exclusively is nearly always doomed to failure, for the patient can bring out new symptoms faster than the pharmaceutical houses can bring out new drugs. The patient-physician relationship becomes a disguised rivalry—the patient challenging the physician to relieve him, the latter becoming scornful and resentful of the misuse of his time and talents. However, ample rewards and gratifications await the physician who is able to treat the hypochondriacal patient on a rational therapeutic basis.

The hypochondriac is recognized

by a peculiar, persistent preoccupation with the body and sensations arising from it. This may accompany the milder neurotic states, may constitute an entity by itself, or may be the initial stage of a psychotic episode of either depression or schizophrenia. Other personality traits such as conscientiousness, stubbornness, seclusiveness, sensitiveness, and instability have often been found in these patients, but with no greater apparent frequency than among other patients.

The cause of hypochondriasis is in dispute. Some authorities believe that the hypochondriac as a child and later as an adult has found the

expression of normal feelings of love and/or hostility too disturbing when directed toward their proper emotional targets (parents, teachers, supervisors, and other authority figures in the patient's life). So, instead of socializing and expressing these feelings, the patient turned them inward, unconsciously fastening them to and expressing their energy through the heart, some innocent segment of the gut, or other handy organ system. If the physician listens carefully, he will detect the heavy emotional investment the patient has made in the offending organs. According to Sullivan, the hypochondriac has given up hope that other persons will appreciate him as a valuable and worthy individual. Therefore, the patient clings desperately to the recital of his symptoms as his only means of gaining the attention and social acceptance he needs, and which he feels he has been denied.

Since society is slow to concede that incapacity can exist on an emotional basis where the thinking and functioning of a person is not grossly or overly disturbed, the patient must convince himself and others that his symptoms are the result of organic dysfunction. Illness is a retreat where one shucks off responsibility, is treated by physicians, waited upon by nurses, and fêted by friends and relatives. Such homage and service is the kind of social acceptance and protection sought by many patients who demonstrate no structural damage. This is their unconscious choice of a solution to their emotional conflicts.

The Patient is Mentally Ill

The physician who undertakes the treatment of the hypochondriacal patient must first accept the fact that positive psychiatric findings are as respectable and worthy of medical attention as are positive structural findings and, further, that the patient is ill. If he is unable to do this, it is unlikely that his patient will be able to do so.

After the physician has done the necessary physical and laboratory studies to reasonably exclude organic change, he should talk with the patient enough to discover some of the

psychiatric factors at work. He may then assure the patient that the complaints are not on an organic basis and tactfully say he does believe tensions and dissatisfactions are present which do account for the discomfort. He can make this understandable to the patient by presenting simple examples of physical changes produced by emotion, e.g. blushing. At this point the physician is almost sure to be met by a vehement denial that the patient has



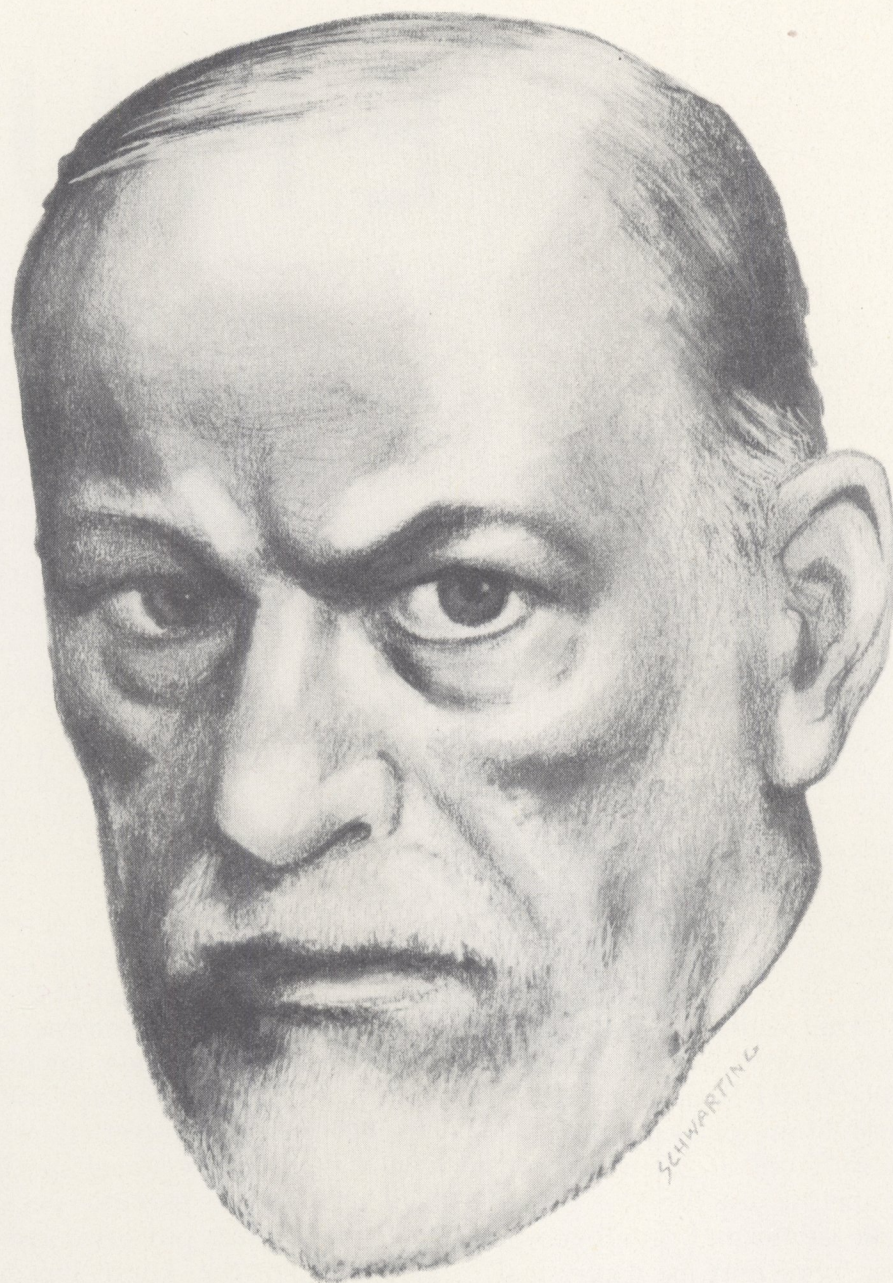
anything on his mind that worries him. By directing the attention of the patient to emotional tensions present before or at the time of, the onset of the symptoms, the physician can help the patient relate and correlate the causative factors. Perhaps a sick child imposed added worry and financial burdens, or the boss for whom the patient works had been particularly crusty and hard to get along with. Usually there is little difficulty in getting the patients to talk, but the physician will note the constant effort of the patient to seek shelter in the herd of his complaints, rather than discuss what brought them on; gently, but firmly, must

the listener head him off from this. Symptomatic relief with the indicated drugs is permissible during the therapy, but should be kept at a minimum. It is most important that the patient clearly understand that the prescriptions are *not* the treatment and are only being prescribed to give temporary relief while the basic cause of his illness is being worked out. The failure to understand this simple fact will confuse the patient and frequently make him lose confidence in the treatment, the diagnosis, and often the physician—resulting in failure of the program.

Friendly Interviews Help the Patient Accept His Illness as Psychiatric

With succeeding interviews, the genuinely friendly, accepting attitude of the therapist will convince the patient that he is worthwhile and his illness real, although of a different nature than what he originally believed. In this manner, both he and the physician achieve one of the goals of therapy. This will diminish conflict, and the patient can talk more freely of himself and of those related to him. Skillful questioning will often bring the patient to a spontaneous realization of needs for certain changes within himself without making him feel "on the spot" on this regime. Real insight may be developed into the psychological reasons for the illness. However, there will be times when the patient will repeatedly test the physician's faith in him. If a patient does come to realize that he is "allergic" to work, or that he responds to the misfortunes of life by getting sick, he may again test the security of his relationship with the physician by asking the latter's opinion of such a person. Finding that the physician thinks no less of him further strengthens his self-esteem, preparing him better to meet the difficulties of life in a more normal fashion. The question of return to work or other activities will come up, but the response, "Well, how do you feel about that?" will leave the responsibility for such decisions with the patient, where it belongs. This is one of the prime aims of therapy—to help the patient reach his own decisions, to handle his own affairs.

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FREUD

MOST DISCIPLINES concerned with human relations have profited by the clinical investigations and conclusions of Sigmund Freud. His contributions have helped to change man's conception of himself. Freud was not always right. No man is always right, not even a genius. But he had something, and he gave it to us.

We owe to Freud perhaps more than to any one man the synthesis and promotion of a more dynamic attitude toward personality

- that personality grows like the body grows, from early, immature beginnings, through successive stages of maturation to full-grown adulthood
- that personality growth depends

not only on the soil which fructifies it, but also on how well the planter tends the plant during its tender years

—that stunted growth is the result of ineffective tillage as much as of deficient germination

—that parents are planters, and children are their plants

—that socialization is learned

—that because of socialization, much of what we feel is repressed, made unconscious, because what we feel is often incompatible with the demands of socialization

—that too much repression sometimes makes a person ill

—that healing such an ill person is sometimes accomplished by helping him become aware of some of these repressions so that he can look at

them and understand them without censorship

—that in the process of gaining such insight the sick person usually develops a strong attachment for the individual who is helping him, and that the cure of the patient's illness often eventuates when, by skillfully guided interviews the therapist makes this attachment seem unnecessary to the patient, and the patient releases himself, becoming an independent, self-supporting, psychologically mature individual.

Freud has not only given us a useful theory of personality and a helpful healing art. He has helped us face ourselves as we really are, neither all animal, nor all angel, but an earthy mixture of both.

ENURESIS

ENURESIS is the term applied to bed-wetting and inadequate bladder control which persist beyond the age when most children have learned adequate control. Most children have achieved this control by the age of three or three and one-half years, although some children, especially boys, are not able to achieve such control until four or four and one-half years. Enuresis can refer to wetting that has never ceased, or to wetting that occurs after the child has achieved control. Infrequent relapses of once a month or so, which are common up to six or seven years, are not usually termed enuresis.

Nocturnal enuresis is the most common form, while diurnal enuresis is rare, except in combination with the nocturnal form. Enuresis is found more often in boys than in girls, and is found as often in children of superior intelligence as in children of subnormal intelligence. Sometimes, there may be a physical cause for enuretic behavior, but more often there are psychological reasons for it. Often, there are other behavior problems associated with bed wetting—nail biting, temper tantrums, thumbsucking, stuttering, and eating problems.

Emotional Upset and Enuresis

Many psychiatrists and physicians have noticed that the onset of enuresis has coincided with emotional difficulties. When these difficulties and conflicts have been solved, the child's enuresis has disappeared. It has also been observed that toilet trained children sometimes begin to wet when a new baby arrives in the family. In this situation, enuresis is a part of a general regression to a more infantile mode of behavior in an unconscious attempt to compete with the sibling for attention from the mother. A prolonged illness which has kept a child in bed and given him attention which he had not had before may give rise to

enuresis. It has also been noticed that some children have started wetting when the parents went away on a trip. A move from one home to another may also precipitate the condition. The frequency of enuresis was one of the most interesting problems encountered among the children evacuated from London during World War II. More children developed enuresis in the comparatively calm atmosphere of foster homes away from the danger of bombing than in the midst of air raids when they remained with their families.

All of these instances of enuresis are thought to be based on a feeling of insecurity on the part of the child. Another reason for enuresis may be that the parents made no effort to train the child. Or perhaps one of his parents was a bed-wetter, with the result that enuresis has special significance to the parents. Because of this, the parents put great emotional pressure on the child for him to achieve bladder control.

The poor bladder control of an enuretic child may be associated with a less stable emotional make-up than that of the child who keeps dry easily. In many non-enuretic children excitement may be the precipitating factor in the "accidents" which occasionally happen after bladder control has been achieved. Exciting situations, such as the first days at nursery school, guests in the house, or going on a trip, may precipitate these "accidents" in children who are easily affected by excitement.

Tension Is a Factor

One of the first questions which should be asked about a child who still is wetting his bed is whether there are tensions operating in his life to postpone his normal inherent progress to dryness. Finding out why the parents are concerned about the problem may be helpful. Perhaps enuresis was a problem in





the home of one of the parents as he was growing up, and that parent is more concerned about his own child's enuresis because of that early experience. Sometimes the physician can reassure the parent that his worry is needless and the parent will lessen the pressure on the child, letting him relax and develop normal bladder control. Sometimes, however, the physician will find that the parent himself has more serious problems that are indirectly reacting on the child, making him feel insecure. The physician may then want to work directly with the parent regarding his own problems. If the child is under four years of age, and it can be established that it is the parents' problems which are the basis for the child's enuresis, the physician may want to work entirely with them. But if the child is old enough—say, six or eight years old—perhaps the physician can work more directly with the child.

Many times a child is put under tension because he is placed in a new situation where he feels uncertain or inadequate. Sometimes he needs only a little more time to feel at home in that new situation. There may be friction between the child and his parents or between the parents themselves which makes him feel insecure. More commonly, perhaps, the mother's handling of the child all day is characterized by pushing, nagging, and unnecessary interference. Occasionally, a child will use enuresis as a weapon against the parent or as a stubborn act of resistance against such handling, and a change in the parent's attitude toward the child is all that is needed to make him feel more secure and able to achieve a normal bladder control. Perhaps the parents are expecting perfect control at an age when a good many children are still wetting regularly or intermittently. If the parents are attacking the problem of enuresis by intensive methods, they are probably finding that they are getting only diminishing returns—not diminished returns. Children who are picked up every two hours during the night are only put under more tension and probably will wet the bed more frequently rather than remain dry all night. Inner security and emotional

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RAPPORT

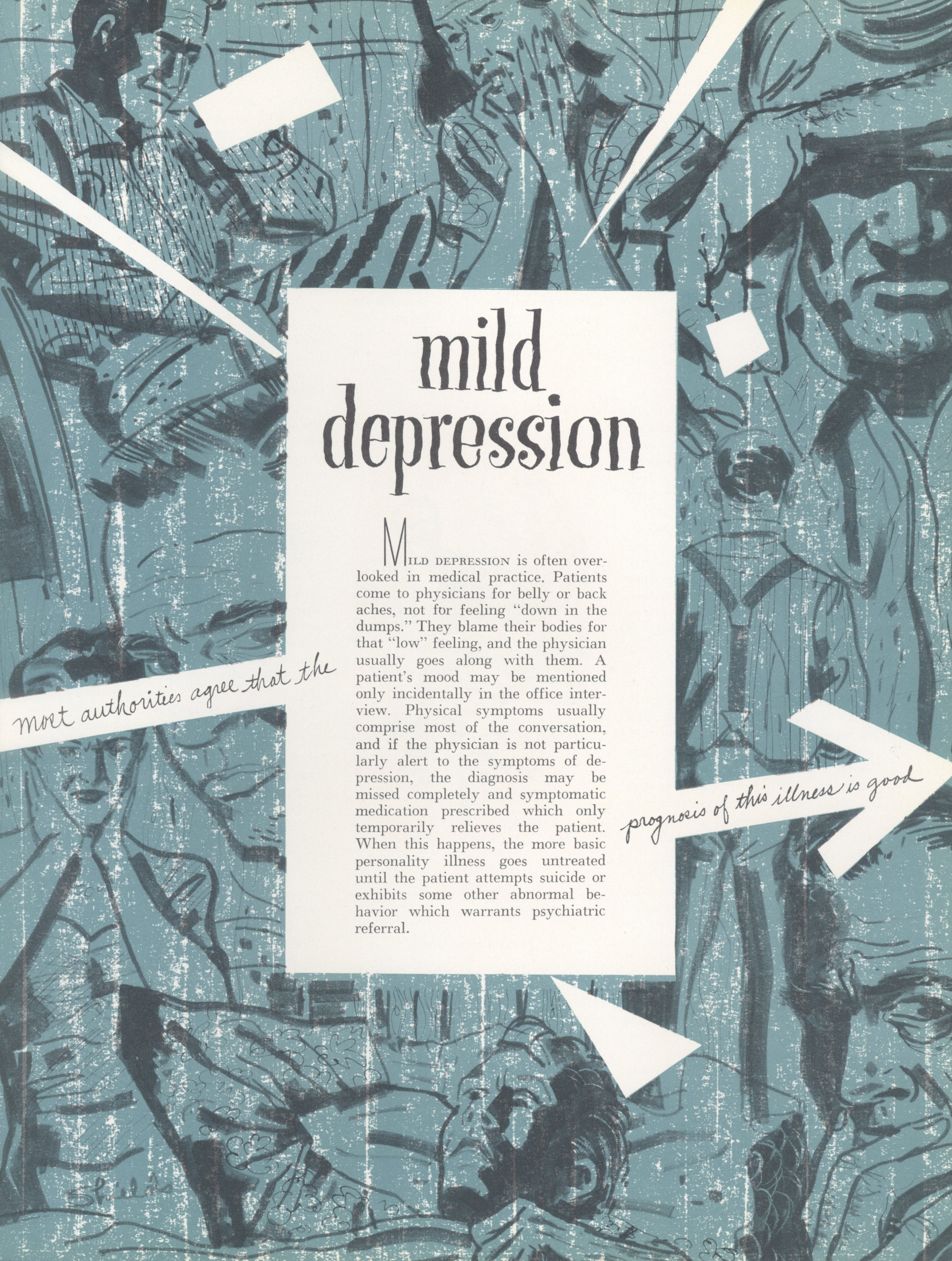
AN OFFICE INTERVIEW should be a comfortable interpersonal communication between the patient and the physician in which the physician is mainly uncensoring and receptive, and the patient is just about anything he wants to be.

Each patient the physician sees presents a unique problem. His life is a continued story to which many authors have contributed—but chiefly the patient and the significant people in his life. The objective of the physician is to become one of “the significant people” in the life of the patient. This is the physician’s first therapeutic goal.

Rapport is the word which designates the physician-patient relationship where the two parties have enough confidence in each other to

discuss serious matters with mutual tolerance and understanding. The simplest way to establish rapport is to like the patient and become interested in his problem. The patient is sick, and he wants to tell somebody about it—especially a person who will believe he is sick even when the most accurate physical-medical diagnostic procedures indicate that the patient has no somatic involvement. The physician who can believe in and have respect for abdominal pain in spite of negative x-ray studies, in chronic headaches when x-ray, E.E.G., and laboratory studies are all normal, in heart trouble when the E.K.G. does not suggest such a diagnosis, can become a most “significant” person in the life of a patient. Such a physician certainly will find

it easy to establish rapport with patients who have psychosomatic illnesses. Once the physician has accepted the fact that the patient is ill even though the cause of illness cannot immediately be demonstrated, the task of finding the cause probably will become much easier. Emotional disturbances are accorded their rightful place in the etiology of illness. Moreover, it is comforting to the patient to know that someone believes he is really sick, not “sick in the head,” not “just imagining,” but sick in his whole body and in his whole life. If the physician offers the patient such a feeling of acceptance, the patient’s self-respect is greatly enhanced, and more important, the physician has established the rapport he needs to help the patient get well.



mild depression

MILD DEPRESSION is often overlooked in medical practice. Patients come to physicians for belly or back aches, not for feeling "down in the dumps." They blame their bodies for that "low" feeling, and the physician usually goes along with them. A patient's mood may be mentioned only incidentally in the office interview. Physical symptoms usually comprise most of the conversation, and if the physician is not particularly alert to the symptoms of depression, the diagnosis may be missed completely and symptomatic medication prescribed which only temporarily relieves the patient. When this happens, the more basic personality illness goes untreated until the patient attempts suicide or exhibits some other abnormal behavior which warrants psychiatric referral.

most authorities agree that the

prognosis of this illness is good

Psychological and Behavioral Changes

In addition to one or a number of somatic complaints, depressed patients usually complain that they have "lost interest in things," that their "pep is gone," and that they have trouble making decisions. Life is a hopeless obstacle course of molehills which have become mountains. The depressive may mention that he has difficulty concentrating. Problems which the patient used to handle in his stride now frustrate and defeat him. When he works, he is unenthusiastic. He has to push himself to do things. He loses the capacity to enjoy life as he did before. If he used to like to make things with his hands after working hours, his tools are probably now rusting from neglect. He is moody all the time. The future looks dull. The present duller. The patient often substitutes idle thinking for action—he gets "lost in thought." Sexual activity is reduced. Male patients feel they have lost their procreative powers. Female patients experience fatigue, vertigo and amenorrhea. Tactful questioning by the physician may reveal suicidal ideas in some patients. There are usually sleep disturbances—either the depressive is unable to go to sleep, or he wakes up easily, often in the early hours of the morning. It is then that he feels the worst, and suicide may be attempted. Later in the day things look better and by evening the patient is "his old self." But the next morning begins another melancholic cycle. This diurnal variation in mood is a significant symptom of depression.

The depressive patient may blame specific organs for his trouble. One depressed patient became obsessed with the idea that his left testicle was the cause of his illness, and he demanded its surgical removal.

Etiology is Incompletely Known

Generally, most authorities agree that the cause of depression is incompletely known. However, there are some theories of etiology supported by suggestive evidence.

Depression may be precipitated by a definite organic illness such as

influenza or tuberculosis; it may follow an intense environmental stress such as loss of a wife, mother, or other loved one; or it may just happen for no easily demonstrable reason. However, some investigators claim that all depressions can be traced to an experience of stress and anxiety which happened at some earlier time in the patient's life. Others claim that there is a hereditary basis for the illness, a predisposition to respond to stress with depression. Still others interpret the illness psychodynamically—attributing the depression to hostility the patient turns against himself because



of feeling guilty for having aggressive tendencies toward other people.

Prognosis is Good

Authorities are in almost complete agreement that the prognosis of this illness is good. Many patients recover spontaneously. Although there is no definite proof that any kind of therapy cures depressed patients, the clinical evidence available suggests that treatment may shorten the duration of a patient's illness or reduce his discomfort while he is sick. The

evidence also suggests that medication and supportive psychotherapy of the type the well-informed practicing physician can give may avert suicide or psychotic depression in many instances.

Severe Cases Should be Hospitalized

Severely depressed patients—those actively suicidal, vegetative, agitated or retarded—should be hospitalized in a neuropsychiatric facility or referred to a psychiatrist. Patients with milder depressions associated with other illness, loss of loved ones or no observable stress can often be adequately treated by the family physician. Medication and supportive psychotherapy is recommended for these patients. Any pains or physical symptoms which can be relieved by drugs should be treated immediately with the proper medication—barbiturates for sleep at night, antidepressants to dispel lethargy in the morning, aspirin for headache or alkaline powders for stomach upsets.

However, usually medication is of no avail in treating mild depressions, and a supportive type of psychotherapy is required. The patient needs the moral support of a firm friendship with someone he can trust. When everything else seems hopeless, a friendly, reassuring talk with the physician may see the patient through. The patient is encouraged to talk about himself, his illnesses, his obsessions. He will usually be glad to repeat his litany as often as the physician can afford to listen. Such a sympathetic audience may in some instances be the patient's only defense against himself or any other defeating factors in his environment. The physician should emphasize to the patient that his illness is not unusual and that his plight is fully comprehended. The patient should be given to understand that the physician is convinced of the ultimate remission of the depression, but that there will be times when suicide will seem to be the only way out. The physician's reassurance will greatly assist the patient to "sweat out" these depressive bouts.

Doing Things is Important

Occupational therapy is important. Something to do is better than

nothing to do—especially for a depressed patient. Regardless of how simple a task is, it may seem impossible to a patient who feels helpless, impotent and doomed to failure. The physician should encourage the patient to stay out of bed during the day and to seek the company of others. He should discourage the patient from going for long, lonely walks by himself, playing solitaire or indulging in any other solitary and semi-automatic behavior which allows his mind to be freely preoccupied with himself without interruptions from other people. Doing things with their hands will keep some patients busy.

But although activity will help many patients, most depressed persons need mainly short and reassuring interviews during the deeply depressed phase of the illness, and deeper, more basic psychotherapy

during the intervals between when the depression has receded. Such deeper psychotherapy, however, in the case of depression, is thought to involve the revelation of guilt feelings. This candid facing of his unconscious hostilities may be too frightening to the patient. He may not be ready to accept the fact that he has these feelings—in that case, the practitioner should exercise extreme caution before embarking on such a potentially dangerous course. Deep psychological probing with depressed patients is especially risky, considering the possibility of suicide. Probably a psychiatric consultation should be recommended for this deeper phase of therapy.

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HYPOCHONDRIASIS

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Many of the more mildly hypochondriacal patients will respond to this therapeutic relationship by thinking of themselves in new, realistic and more satisfactory terms. For some this will mean activities and achievements which were not possible before; for others, it will mean satisfactory performance at the old levels. Still other patients may never completely relinquish their relationship with the physician, but will return occasionally to such a dependable source of security for a "refill."

Psychotherapeutic treatment of these patients is not too time-

consuming; it often prevents unnecessary surgery and medication; it keeps some patients from becoming victims of "quacks;" and, best of all, with a great many patients it works.

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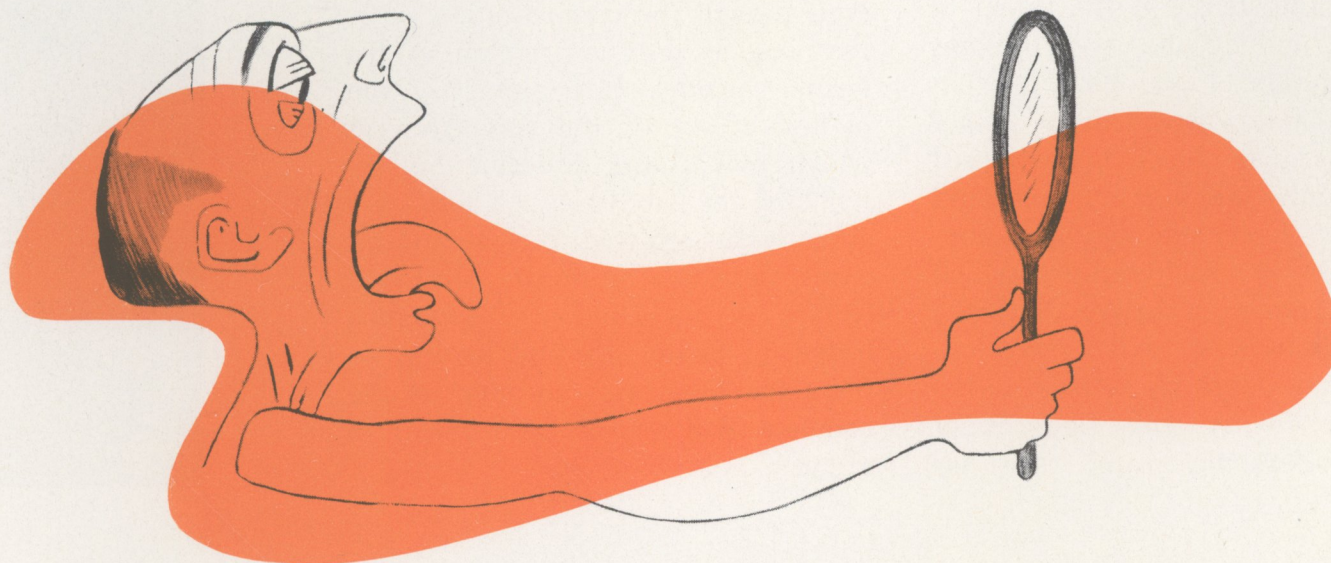
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THE EFFECTS of injuries are not only physical; often an injury has psychiatric sequelae which can be even more disabling than the damage done to the tissues. Various functional emotional disorders may develop from trauma, the most common of which is the post-traumatic psychoneurosis.

Post-traumatic psychoneurosis may result when the injury is relatively minor, regardless of whether it is accompanied by unconsciousness. Particularly if the injury is in the region of the head, the patient may complain of headache, dizziness, nervousness, irritability, difficulty in concentration, and vasomotor disturbance. The headache, if present, may be aggravated by change of position, hard work, and exposure to the hot sun. The patient may also complain of blurring of vision, fatigue, impotence, and restlessness. Often, the patient has no symptoms or signs of physical injury. After a period of time, however, during which he considers the various aspects of the injury, i. e., threat to the self, compensation, etc., his symptoms appear.

Traumatic Neurosis is a Defense

When there is no real injury present and a psychoneurosis develops, the neurosis is probably a defense of the individual against a physical threat to his body. Sometimes the mere threat of injury, such as a near accident, may cause the individual to exhibit the symptoms of a traumatic neurosis. The psychoneurosis following trauma is characterized primarily by the individual's withdrawal from the external world which is the source of the threat to his body, and by anxiety symptoms and inhibition of activities. Psychoneurosis following trauma may occur in anyone, but it is considered normal only when it is mild and shortlived. Everyone may occasionally desire to avoid realities which threaten one's security, but the normal individual will not retain that attitude long. He returns to the world or reality and finds it as it was before his injury. He has

suffered no permanent change in his personality. In a patient with a traumatic neurosis, the personality is more or less permanently altered (if left untreated); the outside world seems to have changed, to have become more threatening, and the individual withdraws and wishes to avoid any contact with this changed world of danger. The personality of the individual becomes reoriented in order to avoid the dangers. After a while, the original purpose of the withdrawal and personality change becomes fixed. The individual shrinks from contact with everyday problems and with other people; his activities become restricted; and he unconsciously develops a desire to become like a child again, dependent upon some protective figure. The individual may be in a constant state of anxiety because he has become so sensitive to the threat of danger that the usual hazards of daily living appear extraordinarily perilous.

Common Signs

Certain symptoms are common to all patients with traumatic neuroses. The patient's life seems to center on and revolve around his injury. He experiences typical dreams characterized by aggressive-submissive action. He may dream of violence where either he or someone else is injured. There is a contraction of the general level of his intellectual, emotional, and physical functioning, and there is a tendency to explosive bursts of temper.

In traumatic neurosis of civilian life, the secondary gain of compensation may be so important that it overshadows the primary traumatic neurosis. The patient puts off the day when he must return to work, even though the compensation he is receiving is only a fraction of his former income. It is not only the money aspect of the compensation which makes him continue his restriction of activities. There are other ways, referred to as secondary gains, in which he profits. He has a feeling of security, of being protected, of being safe and having no fears for the future as long as the compensation check continues to arrive.





Prognosis is Good

A patient with a traumatic neurosis has a tendency to spontaneous recovery. The effects of the trauma on the individual wear away with time and with the readjustment of the patient to his work and social environment. The patient's chances for rapid spontaneous recovery may be lessened if he feels that he gains more by being sick than by being well. The security of the compensation check may prolong the recovery of one injured in civilian life. In a patient with a war neurosis, there is a more immediate secondary gain, the escape from danger and the return to home and family. Many war neurosis cases become chronic because this secondary gain is so powerful in maintaining the symptoms.

The patient should be treated before the secondary gain has a chance to develop; the earlier the treatment, the better the prognosis. Where the problem of compensation is present, a rapid final solution of the question of compensation is desirable. There seems to be a maturation period between the injury and the onset of the neurotic symptoms. If the patient can be reassured and given psychotherapy in this early stage, the possibilities of rapid recovery are much increased. With early treatment the various attitudes toward the environment are not allowed to harden, and the effects of the trauma can be lessened by resuming early contact with the world of reality. The patient meets the world again, finds it relatively harmless, and becomes accustomed again to the ordinary hazards of daily life. The physician and others can do much harm to the patient's chances for recovery if by behavior or speech the suggestion is made that there is some serious injury to the patient. This is especially harmful to patients of a suggestible or hysterical type. The seriousness of the organic trauma must be considered, but a careless word may make the patient feel that the traumatic experience has been a serious threat to the integrity of his body.

Treatment by Psychotherapy

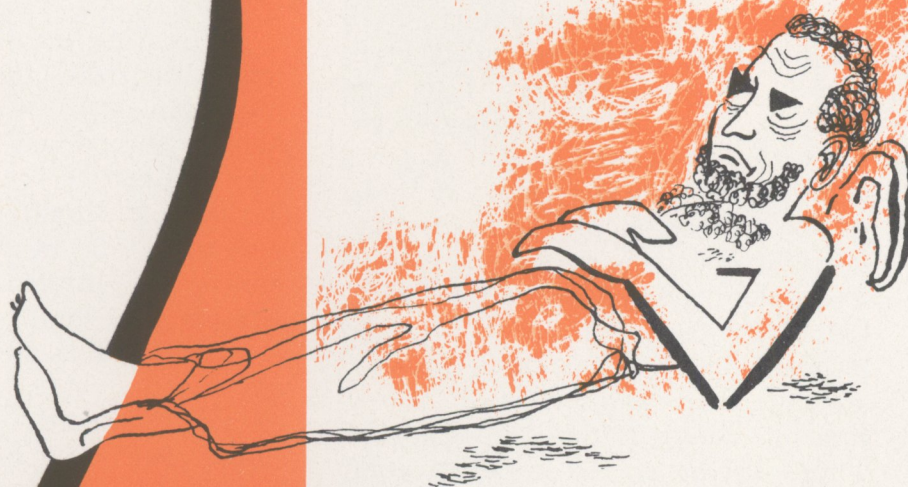
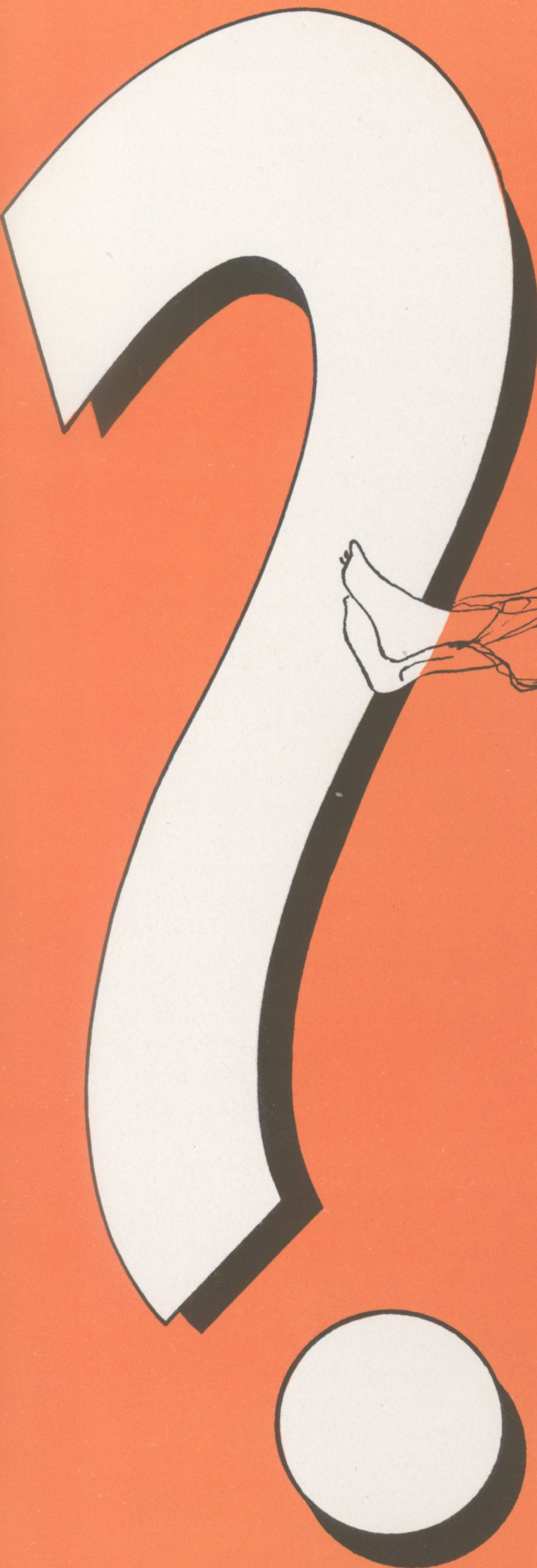
The patient is better treated with psychotherapy by a physician who does not represent the company who

employs the patient. The physician can help the patient to regain his confidence in the world about him and help him to feel that the world is still a safe place and offers no threat to him. If the physician has the power to recommend that the compensation be withdrawn, the patient feels that he has to be on guard to prevent saying something that will stop the compensation. The patient will not want to make the effort to readjust himself to the outside world if the physician represents a threat to his last bit of security.

In treating the patient with traumatic neurosis, the efforts of the physician will be directed toward helping the patient stand on his own feet. Instead of seeing the world as hostile and threatening to him, the patient needs to regain his confidence, see things as they are, and test his own mettle as a man in the real world. The physician can point out the fear caused by the fixation of the traumatic incident in the mind of the patient and help the patient realize the paralyzing effects of that fear. Getting the patient back to work as soon as possible is important, but he should not feel that he is losing financially by returning to work. He needs to be rewarded for trying. He should be returned to work of which he is capable, and his income must be made greater than his compensation award. He will be more eager to return to normal living if there is evidenced to him a feeling of cooperation between the employer and the insurance company in the interest of him, the patient. Many of these patients require special attention, closer supervision, and unusual work situations. Best results are obtained if the work provided for the patient is stimulating to him and serves as a stepping-stone to recovery.

The above-mentioned treatment applies only to patients with traumatic neuroses but with no other disorders. Where there are other psychoneuroses, personality disorders, and other types of psychiatric disturbances precipitated by the traumatic incident, treatment will involve the ordinary methods of psychotherapy used for these disturbances.

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QUESTION: Can chronic fatigue be attributed to emotional disorders?

ANSWER: Yes, in some patients. Alexander and Portis have designated certain fatigue states as a kind of emotional sitdown strike. Many patients who gave no evidence of pathological involvement but suffered from chronic, excessive fatigue, were found to be frustrated in their genuine desires to do what they wanted to do. Further study indicated that these patients were forced by external circumstances or inner compulsions to engage in routine activities which went "against their grain," and they appeared to protest against this coercion by means of an unconscious process which produced fatigue. The investigators observed that often the emotional state of these patients was accompanied by fantasies and daydreams in which the patients pictured themselves as having given up all effort and ambition.

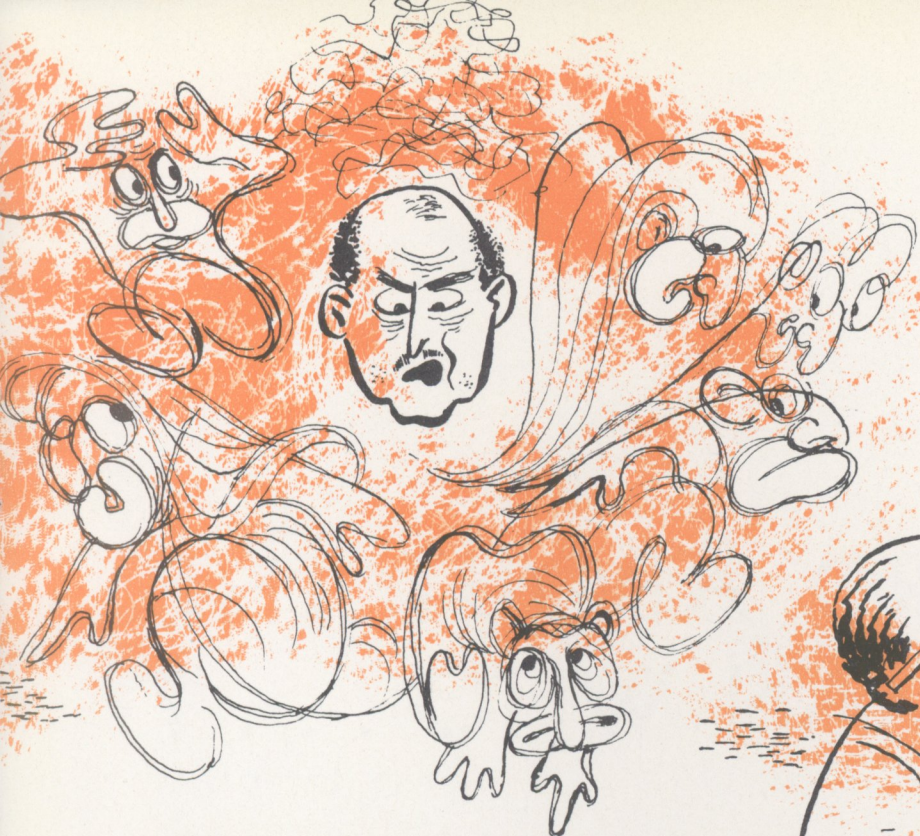
Reference: Alexander, F.: *Psychosomatic Medicine*, New York, W. W. Norton & Company, 1950, pp. 188, 192.



QUESTION: Can migraine headaches be prevented?

ANSWER: Migraine attacks can often be prevented by the patient's understanding of the basis of the tension which helps precipitate the attack and of the unresolved conflicts in his life which aggravate it. Patients with migraine usually are tense, driving, perfectionistic, order-loving, rigid persons who become progressively more tense and fatigued during periods of threat or conflict. These temperamental features lead to frustration, to dissatisfactions about family, financial, or personal status, and to intolerance of periods of low energy in themselves or of relaxed standards in themselves and others. The tension which is associated with repeated frustrations, sustained resentment, anxiety, and fatigue, produces a predisposition to the migraine reaction. If the physician aims at a better understanding of the patient, his life situation, and the factors in his life which constitute a threat to his basic security, he can help the patient understand the situations which precipitate the tensions causing the headaches. The physician can help the patient to resolve his conflicts, and thus prevent the headaches. Wolff estimates that about two patients out of three can be appreciably helped by such therapy.

Reference: Wolff, H. G.: *Headache and Other Head Pain*, New York, Oxford University Press, 1948, p. 380.



QUESTION: How can the physician recognize a severe anxiety neurosis?

ANSWER: Some patients who are experiencing severe anxiety demonstrate a number of mental changes in addition to the regular somatic symptoms which go with anxiety. Their intellectual efficiency is lowered. They think more slowly, make frequent mistakes, and simple problems often puzzle them. Anxious patients also have difficulty thinking up new ideas or adjusting to new situations quickly. They are especially confused in emotional dealings with other persons.

After these patients are relieved of their anxiety feelings, follow-up studies indicate that their intellectual efficiency usually increases. They think more quickly, make fewer mistakes and are able to solve more difficult problems. They also deal with other people more effectively and are less frustrated by the everyday problems of living.

Reference: May, R.: *The Meaning of Anxiety*, New York, The Ronald Press Company, 1950, p. 258.



THE editors welcome any questions physicians would like to have discussed regarding the clinical handling of psychiatric problems in general practice. Every effort will be made to find answers to such questions and to reflect in these answers the best current psychiatric thinking.



QUESTION: What can the physician do (beyond symptomatic treatment) to relieve a patient suffering from severe anxiety?

ANSWER: *First*, win the patient's confidence, so he will talk.

Second, accept what the patient has to say without criticism. This unbridles the patient, and his tensions begin to slacken.

Third, when the patient's emotional difficulties have been revealed, the physician can help the patient review his experience, clarifying his previously unconscious relations with parents and other significant persons in his life. The patient will then find that he cannot possibly escape feeling how and what he does, but for future healthy living he learns to recognize and express, not repress, his emotions. This insight and mentally constructive action will relieve the patient's anxiety, and it will be easier for him to give up his excessive ambitions, his perfectionism or other neurotic ways of handling anxiety. Then the physician can more easily encourage the patient to get out on his own and establish a more workable relationship with other people.

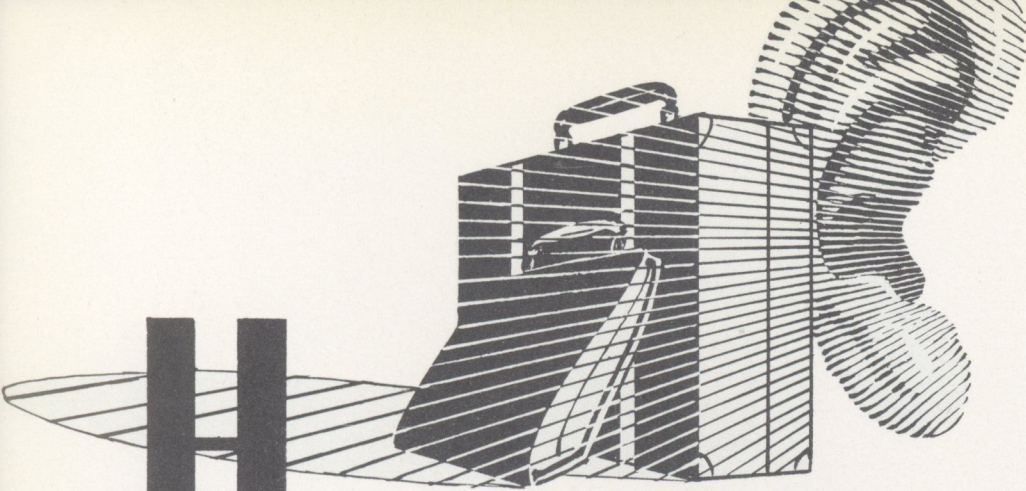
Reference: Beaman, G. B.: *Psychiatry in General practice—Some Aspects of Fear*, New England J. Med. 243:952 (Dec. 14) 1950.



QUESTION: What effect does prefrontal lobotomy have on the behavior of chronic (illness lasting over two years) schizophrenics?

ANSWER: In a clinical and psychological study of 49 chronic schizophrenics Carscallen and his associates found that among their patients there was mainly a reduction in the intensity of their symptoms and an improvement in their behavior. The basic schizophrenic nature of the patients did not appear to be greatly altered. Relapses and exacerbations of symptoms were not infrequent within the six-month postoperative period in which the patients were studied. Those patients in the group whose illness had lasted over five years reacted less favorably to treatment than those who had been ill less than five years.

Reference: Carscallen, H. B., Buck, C. W., and Hobbs, G. E.: *Clinical and Psychological Investigation of Prefrontal Lobotomy in Chronic Schizophrenia*, Arch. Neurol. & Psychiat. 65:206 (Feb.) 1951.



HAVE YOU HEARD ABOUT THE TRAVELING SALESMAN WHO . . . ?

THE fifteen-year-old sitting warily on the edge of his chair in the physician's office is frightened. His mother, a large untidy woman, asks impatiently:

"But, doctor, did you examine him thoroughly?"

Dr. Smith has just finished making a physical examination of her son, Jack, and found nothing wrong.

"Yes, and I found nothing abnormal. Just why did you bring him to see me?"

She is embarrassed and does not want to talk about it, but the physician is persistent and she finally overcomes her reluctance.

"Well, doctor, my neighbor called me and told me that Jack was acting peculiarly. He's disgraced me and the family."

"What did he do?"

"Well, there's a big bush near the sidewalk between our property and our neighbor's, and my neighbor can see it from her upstairs window. She was looking out the window and saw Jack sitting by the bush and a lady was passing by, and—oh, it's just too terrible—Jack had his trousers open and was exposing himself."

Dr. Smith sneaks a glance at Jack, seated as far away from the doctor and his mother as he can get. His face is red and he is looking at the floor.

"You're sure that's what he was doing?"

"Yes, my neighbor called me and I went over and saw him myself."

"And what did you do about it?"

"I marched him home, of course, and locked him in his room. When his father got home—he was on a

business trip at the time—he gave him a good thrashing. Are you sure, doctor, that there's nothing wrong with him?"

"There's nothing wrong physically. He's probably mixed up about sexual matters, but there doesn't seem to be anything else wrong."

As Dr. Smith talks further with the mother and later with the boy, he finds that although Jack is a seemingly normal boy, he has been rejected by both his mother and his father. His father is on the road a great deal in his sales job and is not home more than a day or two every two or three weeks. His mother lavishes attention and affection on Jack's younger sister, but she does not show this same affection for Jack even though she closely supervises all his activities. Jack's relationship with his father is not good, either. In Jack's own words, "Aw, I can't talk to him," is evidence of a lack of fellowship between the father and son.

Now, at fifteen, the boy is beginning to show some of the effects of the lack of a close relationship with his father—a misunderstanding of sexual matters, a feeling of being too much "bossed" by his mother, a lack of someone with whom he can talk over his problems and from whom he can learn about the things he needs to know as he approaches maturity.

Every child needs two parents. A mother can provide for the physical needs of her children without a father's assistance, but she cannot provide the father figure necessary for their adequate psychological adjustment. Most fathers do not realize

how much they contribute to the emotional growth of their children. Sons, especially, need to have a father's example when they are learning the special male attitudes and activities necessary to their success as men. Of course, when a boy grows up without his own father, he may substitute some other male figure as his masculine ideal. But this substitution is never as satisfactory as having one's own father as a comrade and companion.

Dr. Smith has asked Jack's mother to have her husband come in to see him. He finds him reluctant to talk about his family and himself, saying that he would not have come if his wife had not been so insistent.

"Hell, doc, I don't see what I've got to do with this. I'm a busy man. Can't you and my wife and the kid settle this among yourselves?"

Challenging statements like this will tempt the physician to take the bait and respond similarly, i.e., challenge the father with something like: "No, Jim, we can't settle this among ourselves. The solution must necessarily include you." Thus, although the physician may feel that he has told the truth to this father, at the same time the physician's challenging manner will probably put the father even more on the defensive than before. And more important, the patient (the father is the patient in this instance) will be encouraged to avoid discussing himself if the physician manifests such a challenging attitude. Some remark, such as, "You must be very busy. Does your business take you out of town much?" might turn the conversation to a

discussion of the father's activities and perhaps to their effect on the children. Thus, the physician can indicate to the patient that he is interested in the patient himself, *his* viewpoints, *his* attitudes, and *his* feelings, rather than in challenging or criticizing him, and the patient then can be more reasonably expected to cooperate with the physician in therapy.

Once the physician has started the patient (the father) talking about himself, half the battle of psychotherapy has been won. Self-expression in an atmosphere where the patient does not feel inhibited gives the physician an opportunity to learn what basic motivations are operating in the patient's personality. Therefore, it behooves the physician to allow a considerable portion of the early interviews with the patient to be devoted to a cathartic release of the patient's emotions. This the physician can accomplish by giving the patient the feeling that what *he* says is important, not what the physician says, and that anything the patient says will be accepted by the physician in confidence and without censorship.

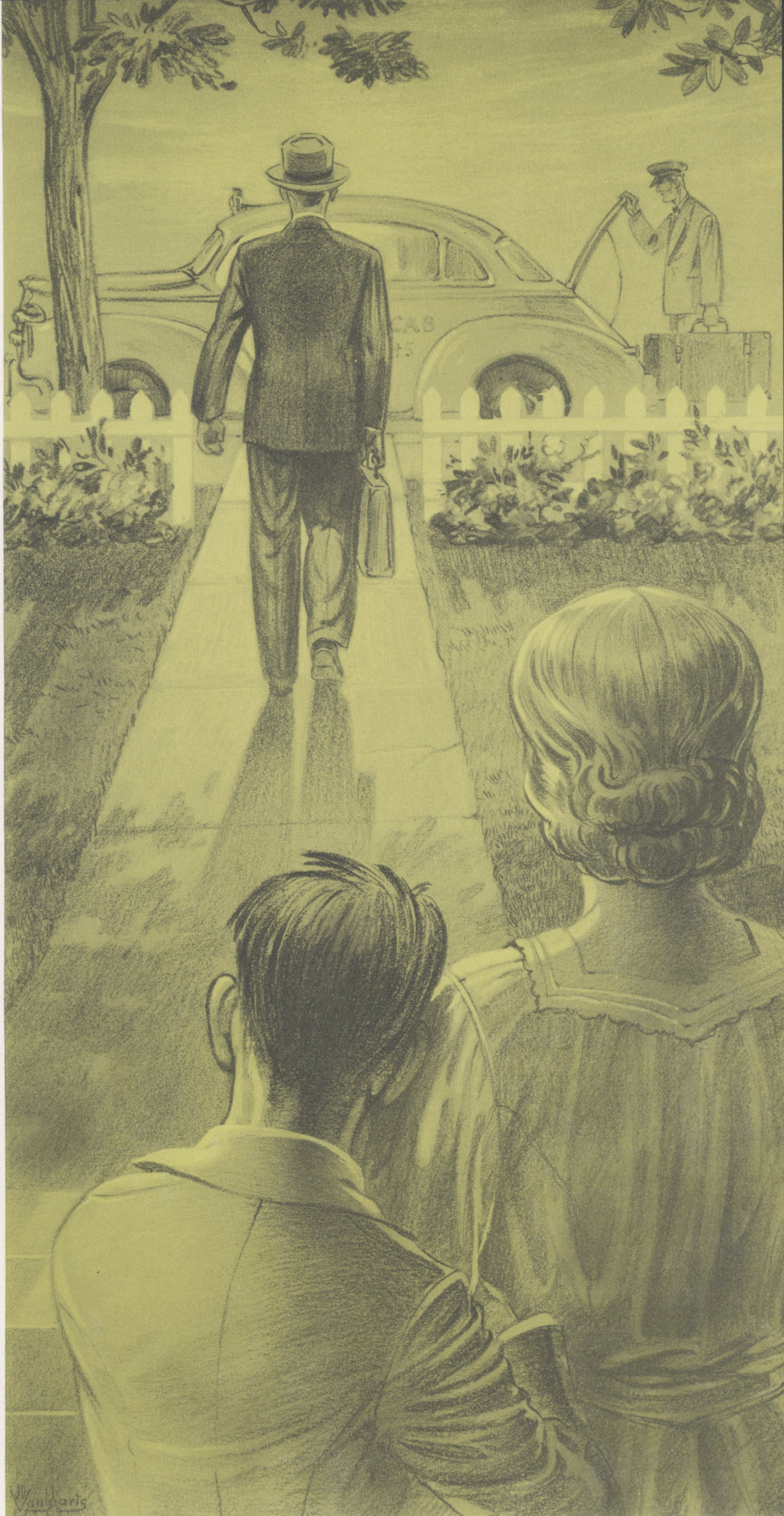
A properly permissive, accepting attitude on the part of the physician will encourage the patient to examine the facts of his own life more freely. Because the physician is not critical of the information which the patient reveals about his life history, the patient can more easily accept facts about himself which previously he had not been able to face. Often, the patient will begin to examine himself critically under such benign psychotherapeutic conditions. For example, the father in this case might very well discover, as many fathers in similar circumstances have found, that certain unsatisfactory conditions in his own earlier life had a rather direct bearing on his present conduct,

—that, for example, his own father and mother, as he remembered them, were unhappy in marriage,

—that he had never had a companionable relationship with either of his parents,

—that he never went out with girls much as a young man,

—that after much persuasion his

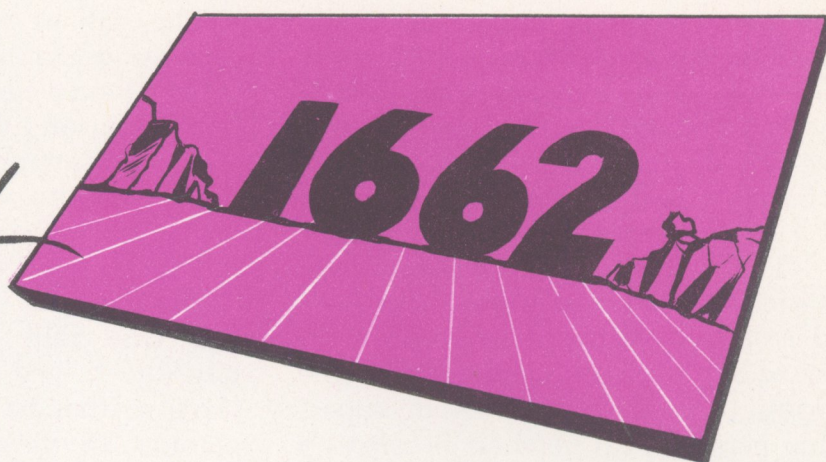


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B.R.

Case History



THIS ARTICLE is a discussion of a case that has been studied by a member of the editorial board.

CASE NUMBER 1662

Presentation of the Patient: In the fall of 1946, a 20-year-old male was seen on the medical service. His symptoms had been present for seven or eight years and consisted of recurrent diarrhea, often with mucus and sometimes with blood, and as many as eight to twelve bowel movements a day. He had a poor appetite and was very thin and run down.

During the years he had been ill the patient had been seen by many doctors and had been in several hospitals. He and his parents were becoming discouraged, because from their point of view they had spent a great deal of money to no avail.

Physical Examination: Physical examination of the patient was essentially negative except for spasticity throughout the lower bowel, which was revealed by x-ray. On several occasions the patient's red blood count had dropped to around three million.

Psychometric Examination: Psychological examination of the patient showed his I.Q. to be 130.

Family Situation: The patient talked about his strong attachment for his mother and his inability to be friendly with his father. Apparently, his mother had rather completely dominated his life. When he left home and entered the university, and when he entered the army, he developed symptoms which he claimed necessitated his going back home to his mother. He had been reared in a strict moral tradition.

Although he wished to rebel against the strict code that had been imposed upon him, he experienced guilt feelings whenever he did so.

Treatment: After the diagnostic work had been completed, both the internists and the psychiatrists agreed that the medical and laboratory findings were probably secondary and that emotional factors were primary. When this idea was presented to the patient, he was very alert to it, seemed to think that it was reasonable, and was anxious to go ahead and do something about it. He obtained a part-time job so that he could support himself and continue with his treatment.

The patient was seen a total of fifteen times. The first six visits were regular, but thereafter he came only when he felt it was necessary. As his problems were discussed, there were days of dramatic improvement in symptoms with complete cessation of the diarrhea. During these periods, he exhibited considerable self-confidence. In a little while, however, he would again become depressed and would say that he felt inferior and could not do anything. Very early he expressed his own recognition of the relationship between his emotional state and his physical symptoms, because his intestinal upsets were worse when he was having disputes with his parents. Several times he visited his home, which was about four hundred miles away, and on each occasion he had a recurrence of diarrhea. This experience added to his insight.

The patient had a great fear of "being analyzed," and it seemed that it was somewhat of a bogey to him.

He was told that this was not too necessary and that an attempt would be made to try to help him first to improve his job situation and then work out with him some of his emotional problems.

In the main, the patient showed himself to be a quite passive and dependent individual. However, he made erratic stabs at being self-assertive and carrying on his own affairs without help. During the course of treatment, the therapist encouraged the patient whenever he made a positive effort to handle some situation independently. Always the therapist voted for whatever he was anxious to do, provided he had initiated it himself. The patient's self-confidence was developed by reassurance that the therapist knew he could handle his affairs himself and could do quite well. Sometimes, however, the therapist would challenge him; this often elicited a response of self-assertiveness.

The patient wanted to rebel against his strict moral upbringing, but felt guilty about doing so. Whenever he went out on a party, he would have a strong guilt reaction. While he was being treated, he developed many compromises of his own and made some movement into social activities. However, his background of morality was always an inhibiting force which interfered with his relationships with girls. Whenever he did propose some social overtures, he was encouraged.

Twice during the course of treatment, events in the patient's life precipitated emotional conflicts. The first was occasioned by the loss of his job. He had been discharged because

he was rebellious and easily upset. The therapist explained that this sort of thing often happens when one is young and just getting started; as a result, the patient was not too discouraged and apparently recovered his balance immediately.

The other set-back was more serious. It occurred at about the middle of the treatment and was occasioned by an uninvited visit by the patient's mother. She was an imposing person, with her hair braided up tightly on the top of her head. She appeared madonna-like, rigid, set, gloomy, and grim. She said she thought the treatment was not doing any good and that the patient's trouble was caused by inheritance from the father. Outwardly, the therapist agreed with her and did not fight her. The patient vacillated between his mother, who attempted to make him return home, and his own desire to go on with the treatment. The therapist let him decide for himself. After some interval, he returned for treatment.

The patient finally came to the conclusion that his parents had not really wanted him very much in the first place; and that they were overdoing their attempts to show him that they loved him, when they really did not. There was so much to support this that when the patient mentioned it, the therapist said that it probably was true. The therapist reassured him and helped him rationalize this view, so that he would not hate his parents. In the main, the therapist pointed out that parents have their problems, too, and should hardly be condemned for things they cannot help.

In his relationship with the therapist, the patient kept illustrating how he felt not wanted. He felt that he was demanding too much attention and taking too much of the therapist's time. He wondered just what his mother's real attitude toward him was, and decided that she had been trying to keep him sick. This concept was reinforced by one special event in which his mother had had an

argument with him. She had insisted that he be sure to put a total disability clause in his insurance. He did not want to think of himself as totally disabled, but she was quite insistent on it.

The last time the patient came in for treatment he said that he had decided to go back to school and finish his original plan for a career that he had always wanted in radio. At the very end the therapist challenged him, saying that he wondered if he really could do it, and gave the impression that he doubted the patient's ability. The patient left, saying, "By golly, I'll show you."

Disposition and Follow-Up: The therapist saw the patient two years later and has had reports on him through friends as late as three years afterwards. He is not having any symptoms, has stayed away from home, has finished his school, and has a steady job. Apparently, he is happy and content in his present situation.

COMPENSATION COMPLEX

Continued from page 61

The problem of compensation is a difficult one. If compensation is continued, the patient's recovery is sometimes unnecessarily retarded. Nevertheless, the neurosis is related to the traumatic incident and probably would not have occurred without it, so it would be unfair not to give the patient the compensation to which he is entitled.

Suggested Reading

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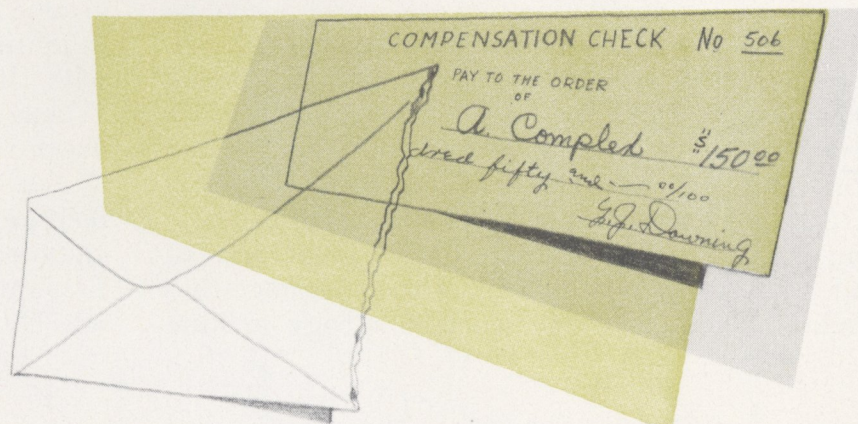
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ENURESIS

Continued from page 55

relaxation are necessary for the child's bladder function to progress to the point where he can learn to retain urine throughout the night. Some authorities maintain that children should not be picked up at all during the night. The suggestion is made that if the child is eight years old or over, an alarm clock can be set to wake the child, and he can take the responsibility for getting himself up.

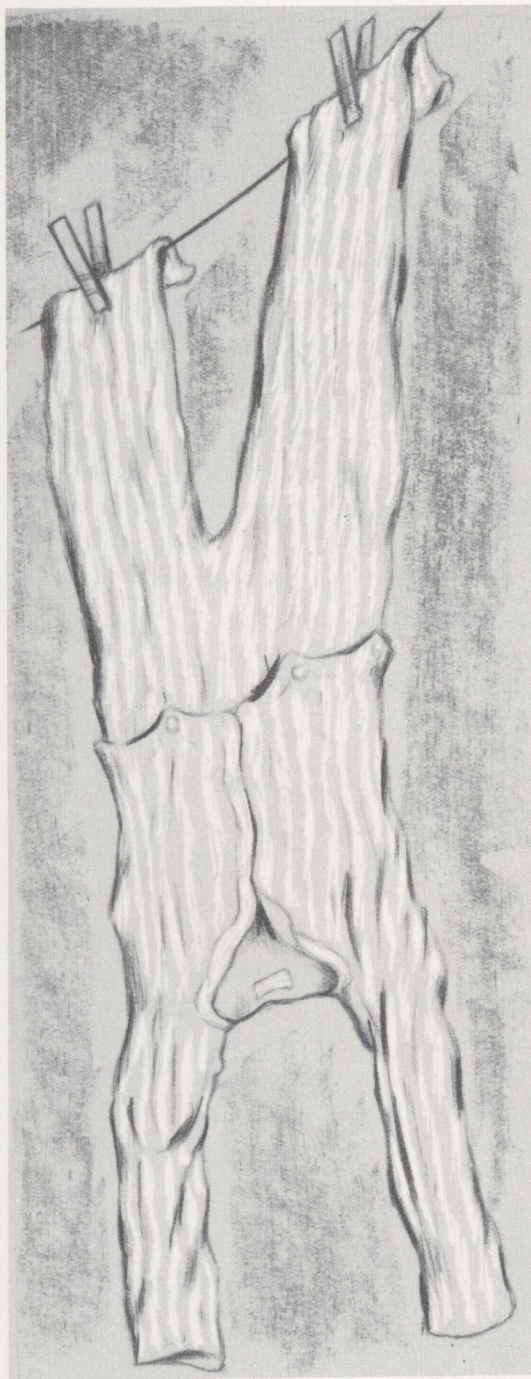
Occasionally, it is a problem for the physician to decide whether a child should be given a complete urological examination. Of course, there are a few cases where the symptomatology or the results of urinalysis demand further investigation. In most cases, however, there is no reason to suspect an organic cause for enuresis. Most small children experience severe emotional trauma from hospitalization, anesthesia, and instrumentation. Unless there are very clear indications for instrumentation, it is not advisable to subject the child to it.

What the Physician Can Tell the Parents

Although enuresis is sometimes a most baffling problem for both parents and physician, there are a few points which the physician can emphasize which will help the parents to cope with the problem. Parents should be reminded that making an issue of bladder control will not help matters. It is only one of many things that children are expected to learn. It normally is a by-product of a spirit of friendly cooperation between parent and child. The mother, especially, will want to make consistent efforts to win the goodwill of the child. Threats, scolding, shaming, rewards, or punishment are usually ineffective as means of training, and many times are actually harmful. The self-confidence of the child needs building up. If the child feels that his parents think he will never be able to do better, he will lose all incentive to improve. Certainly, a parent should not further fix the bed-wetting by saying, "His father wet the bed until he was

fourteen," or "He will grow out of it." The child will be more encouraged to do better if the parent gives approval when his bed is dry. Bribing the child with material rewards or with "affection" is a poor idea. Consistent goodwill and pleasant day-to-day living between mother and child, with a simple explanation of what is expected, is usually enough to solve the problem.

The practice of restricting fluids in the late afternoon and evening before bed-time may help in some cases. This should not be carried to



an extreme, for denying a child milk or water for supper may lead to an emotional upset which may be more conducive to bed-wetting than the fluid would be.

Parents will want to avoid making the enuretic child feel that he is dirty. That not only contributes to a feeling of inferiority, but also may lead to mistaken ideas about the natural sexual functions. Because the child cannot distinguish between the organs of sex and of excretion, he may find it difficult in later years to avoid transferring the idea of filthiness to the natural sex functions.

Perhaps one of the most important things a parent can do for an enuretic child is to help him grow in independence and self-confidence. Being casual about the matter of bladder control, and never showing annoyance when he cannot attain that control immediately, are important. Most children can achieve bladder control if they are not rushed into it before their bodies are ready for it and if they can live in an atmosphere where they are not constantly uneasy and under tension. If day by day the child's parents create in him a feeling of security and of being loved, enuresis will probably not be a problem.

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TELLING THE SURGICAL PATIENT THE TRUTH: Most surgeons seem to have an intuitive understanding of the psychologic importance to the surgical patient of being told the truth about his surgical status. With the anxious patient there is a widespread tendency to join the patient in his denial of the unpleasant consequences of surgery with an "everything is going to be all right—just leave the worrying to me" attitude. With the patient who prides himself on his independence and capacity "to take it," the surgeon will probably grant his request, knowing that telling him the facts will be more reassuring than any minimizing of reality.

Some patients, however, have an unusual capacity to deny or minimize reality and also value highly their independent roles in life. Such patients are sometimes faced with the threat of invalidism from removal of important parts of the body. In this case, permitting the patient to continue in ignorance of the true nature of the bodily changes produced by surgery may cause him to develop severe post-operative emotional reactions.

The surgeon will need to guard against this development. He will need to be able to predict which personalities will require special pre-operative psychologic preparation for major surgical procedures. Also, he will need to develop a technique for giving these patients factual information in such a manner that it has emotional as well as intellectual meaning. The patient should be psychologically prepared for the role he must play with his altered body.

Rosen, V. H.: The Role of Denial in Acute Postoperative Affective Reactions Following Removal of Body Parts, *Psychosom. Med.* **12**:356 (Nov.-Dec.) 1950.

PSYCHIATRIC THERAPY WITH CHILDREN: A play situation is generally accepted by most psychiatrists as best for a child to express himself enough so the therapist can intelligently understand the child's problem. Play therapy actually is a drama in which both the child and the therapist participate. The therapist is a skillful, participant observer who quietly encourages the child to write the script. In a play situation a child's feelings, his socially inefficient solutions to his conflicts are

more easily comprehended, and the therapist is better able to help the child find new and happier, more successful solutions to his problems.

The over-all goal of psychotherapy with children is that the child acquire a new spontaneity, less fear of his own impulses, a new command of himself, and a more solid respect for himself as a person.

Szurek, S. A.: Problems Around Psychotherapy with Children, *J. Pediat.* **37**:671 (Oct.) 1950.

ANOREXIA NERVOSA, SYMPTOMS AND PSYCHODYNAMICS: Some patients with anorexia nervosa are not suffering from a simple, circumscribed illness involving appetite, weight loss and amenorrhea, but they are in a very wide sense maladjusted persons. Nemiah found from an extensive clinical study of 14 such patients that in these cases the disease syndrome involved not only a disturbance in the ingestion of food as a function of nutrition, but that food and eating were endowed by the patients with unusual meanings, and that the erotic function of the mouth was often disturbed. He also found that these patients were immature, often infantile, emotionally cold and generally seemed to have difficulty in establishing social relationships on an adult basis.

Nemiah's clinical findings further indicate that many of his patients had overly protective parents, and that the patients responded to this over-protection by being excessively dependent on the parent; that the patients were often hostile to one or both of their parents; that they were often preoccupied inwardly with feelings of inferiority; and that they exhibited a strong need for support and dependence in human relations, while at the same time desiring freedom and independence.

Nemiah, J. C.: Anorexia Nervosa, a Clinical Psychiatric Study, *Medicine* **29**:225 (Sept.) 1950.

LIFE SITUATIONS, EMOTIONS AND AURICULAR ARRHYTHMIAS: A group of 26 unselected patients with paroxysmal auricular and nodal tachycardia and auricular fibrillation were found to be unusually susceptible to prolonged anxiety, resentment, conflict, and depression when they encountered stressful life situations. It was found that attacks of

arrhythmia occurred much more frequently when patients were suffering from one of these abnormal emotional conditions. The coincidence of arrhythmia and stressful life situations was noted in all patients regardless of whether structural heart disease was involved. Physical exertion, tripping, postural changes, and sudden experiences of fright commonly started a tachycardic attack, but the patient's susceptibility to such precipitating stimuli was found to be greatly influenced by the patient's life situation and emotional state.

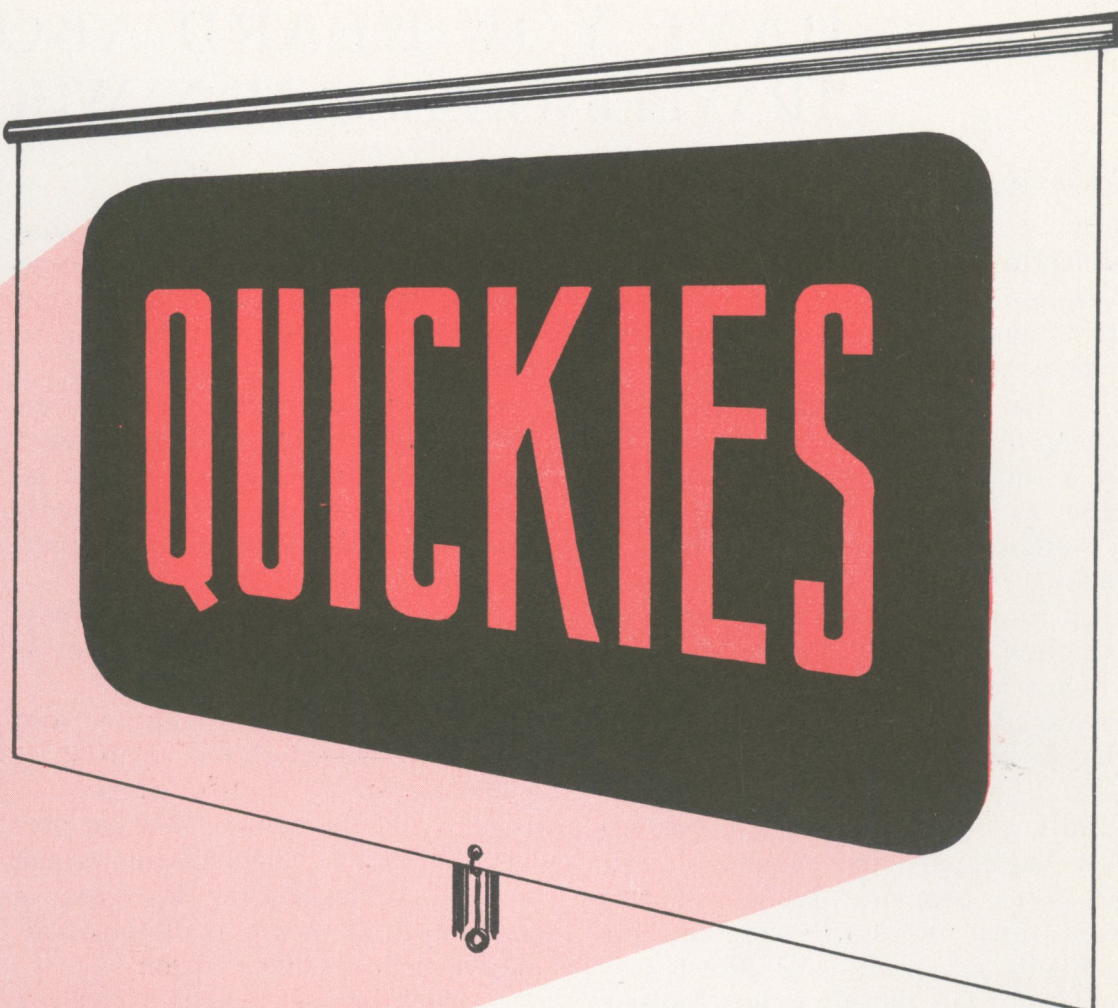
Duncan, C. H., Stevenson, I. P., and Ripley, H.S.: Life Situations, Emotions, and Paroxysmal Auricular Arrhythmias, *Psychosom. Med.* 12:23 (Jan.-Feb.) 1950.

HORMONAL INDUCTION OF PUBERTY: An inadequate masculine physique such as short stature, poor muscular development, and failure of normal genital growth can often cause an adolescent boy a considerable loss of self-esteem and consequent personality difficulties. This led Schonfeld to supplement psychotherapy in such cases with hormonal treatments designed to correct the physical inadequacies which were largely responsible for the boy's personality difficulties.

Testosterone propionate injections were used in the beginning. Methyl testosterone was given orally, 20 to 30 mg. daily for a period of two to three months. Hormonal therapy was then discontinued for about two months. After this interval the course was repeated. If the object of therapy was primarily the stimulation of the boy's growth in height, longer intervals between courses were used to allow a partial recession of the effects of the hormones. This permitted several courses of hormones to be administered before puberty was finally induced.

However, if growth in the boy's height was not the primary object, treatment was given more continuously along with chorionic gonadotropins until mid-puberty. At this stage pubic hair is developed at the base of the penis, axillary hair first appears, and the genitalia are of normal size for the boy's age group.

It is emphasized that hormonal induction of pubescence alone is inadequate in such cases since it then appears to the boy that he needs



medicine to make his body do something that it is supposed to do naturally. The entire treatment must be supported by adequate psychotherapy and used only in carefully selected cases.

Schonfeld, W. A.: Inadequate Masculine Physique as a Factor in Personality Development of Adolescent Boys, *Psychosom. Med.* 12:49 (Jan.-Feb.) 1950.

REACTIVE PSYCHOSIS IN ADOLESCENCE: Clinical studies indicate that acute psychotic episodes may occur in adolescence. These episodes are often accompanied by severe anxiety and sometimes depression. Delusions and hallucinations may also be present. These symptoms, however, do not necessarily indicate that the adolescent's personality will disintegrate. After the acute phase of the attack, a good emotional relationship can often be established with the patient, which indicates a good prognosis for many of these cases. Often such patients recover spontaneously or ultimately respond very well to psychotherapy. The psychotic episode is usually caused by some unusual stress in the adolescent's life situation or emotional condition. For example, a severe

psychosexual conflict often may result from an undue attachment to the parent of the opposite sex.

Warren, W. and Cameron, K.: Reactive Psychosis in Adolescence, *J. Ment. Sc.* 96:448 (April) 1950.

EMOTIONAL DIFFICULTIES RELATED TO TUBERCULOSIS: Emotional shock and depression are the most common reactions of patients to the discovery that they have tuberculosis. According to most investigators, the depression and anxiety experienced by tuberculous patients are due to many things in addition to the physical symptoms. Furthermore, their clinical findings indicate that such patients should be allowed to indulge in these feelings without too much interference at first. After all, tuberculous patients have reason to feel depressed.

Knowledge and understanding of these emotional reactions in the light of the patient's pre-illness personality are essential for any person who plans to deal effectively with tuberculous patients.

Braceland, F. J.: Book review of a Psychiatrist Looks at Tuberculosis by Erick Wittkower, *Ment. Hyg.* 34:663 (Oct.) 1950.

HAVE YOU HEARD ABOUT THE TRAVELING SALESMAN WHO . . . ?

Continued from page 65

only sweetheart reluctantly consented to marry him,

—that he had never had a satisfactory sexual relationship with his wife or with any other woman,

—that because of these things he was probably led to avoid his wife in a socially acceptable manner as often as he could,

—that this probably led him to take a travelling job which would keep him away from home most of the time.

Once the patient has made a self-examination like this, it is probable that he will see that he himself has desired an estrangement from his family and that this estrangement has been partially responsible for his son's behavior. Insight of this kind must necessarily precede the patient's accepting any direct suggestions from the physician. Indeed, the patient will probably directly ask the physician for suggestions about what to do when he achieves such insight. The physician may then safely proceed with a more directive type of psychotherapy, as Dr. Smith did, when he said:

"Your son needs your help. He's confused about certain things, and he needs your guidance. He's at an age now when he can easily be led into doing things that are repulsive to society and for which he, and perhaps you, will have to pay later. Tell me, does your wife make all the decisions about the children? Does she decide when they are going to camp, whether your son should be allowed to learn to drive a car, who shall be your daughter's friends?"

"Yes, doc. I'm never there to make any decisions. She runs the house and the children and I bring home the bacon. I realize now, however, that because of my job, I have left all that to her. What do you suggest?"

Dr. Smith then explains to the patient how most mothers who dominate their homes never let their children become independent,

—how the patient's own wife is heaping smother-love on her

daughter while she rejects her son,

—how the patient's son, not having his father as a companion and example, is constantly compelled to take orders from a female,

—how this may keep the son from developing kindly feelings toward the female sex, feelings which he should have, especially when he is older and is thinking about selecting a wife, and

—how the son may become passive and submissive and not feel at home in his masculine role.

The physician can explain also that a boy reared almost entirely by a female may identify himself so much with his mother that he prefers the passive, yielding role of the woman, perhaps later becoming a partner in a homosexual relationship with some older person,

—that the son needs a father's example and guidance as he is growing up.

—that Jack needs proper guidance to an understanding of himself, his sexual functions, and his role as a man, which his father can give him.

Dr. Smith can further point out that because many fathers have occupations far removed from their families, the children are no longer able to learn about their father's work and his contribution to the home. The physician can indicate how important this is to the child and that often a child can grow up and never know the meaning of work and what it takes to earn a living. The physician can suggest that the child needs the father's knowledge of worldly affairs and his masculine point-of-view if he is to be properly prepared for maturity in the world outside his home.

"I understand, doc. This whole thing is related to me and my being away from home so much. I'd like to do something about it. What do you think I should do?"

At this point the physician can make some practical suggestion such as, "Perhaps there is a job you could fill in your company which would not take you away from home so

much. Or, if you can't do that, perhaps you can make the time you can spend with your children mean more to you and to them. You and Jack might start participating together in a hobby or sport which interests both of you. Because of the demands of your job, you are probably in such a habit of being busy that when you do have some time to relax and be with your wife and children, you find that you unconsciously become busy again. The need to be busy is so great that you probably 'make' jobs for yourself. Much of the time you spend doing these other things might be spent with your family, giving your children the companionship they need."

The fact that the patient has been allowed to express *his* viewpoints, *his* attitudes, and *his* feelings has prepared him to receive such direct suggestions from the physician. Even if it is not possible for him to change his job so he can spend more time with his family, he will probably attempt to change his relationship with his wife and children in such a way as to improve the family situation. Thus, the physician has been able to help a "busy" father to gain a better understanding of himself that will pay off for every member of the family—especially for the son.

Suggested Reading

Bossard, J. H. S., and Boll, E. S.: *Family Situations*, Philadelphia, University of Pennsylvania Press, 1943, p. 144.

Gardner, L. P.: *An Analysis of Children's Attitudes Toward Fathers*, *J. Genet. Psychol.* 70:3 (March) 1947.

———: *A Survey of the Attitudes and Activities of Fathers*, *J. Genet. Psychol.* 63:15 (Sept.) 1943.

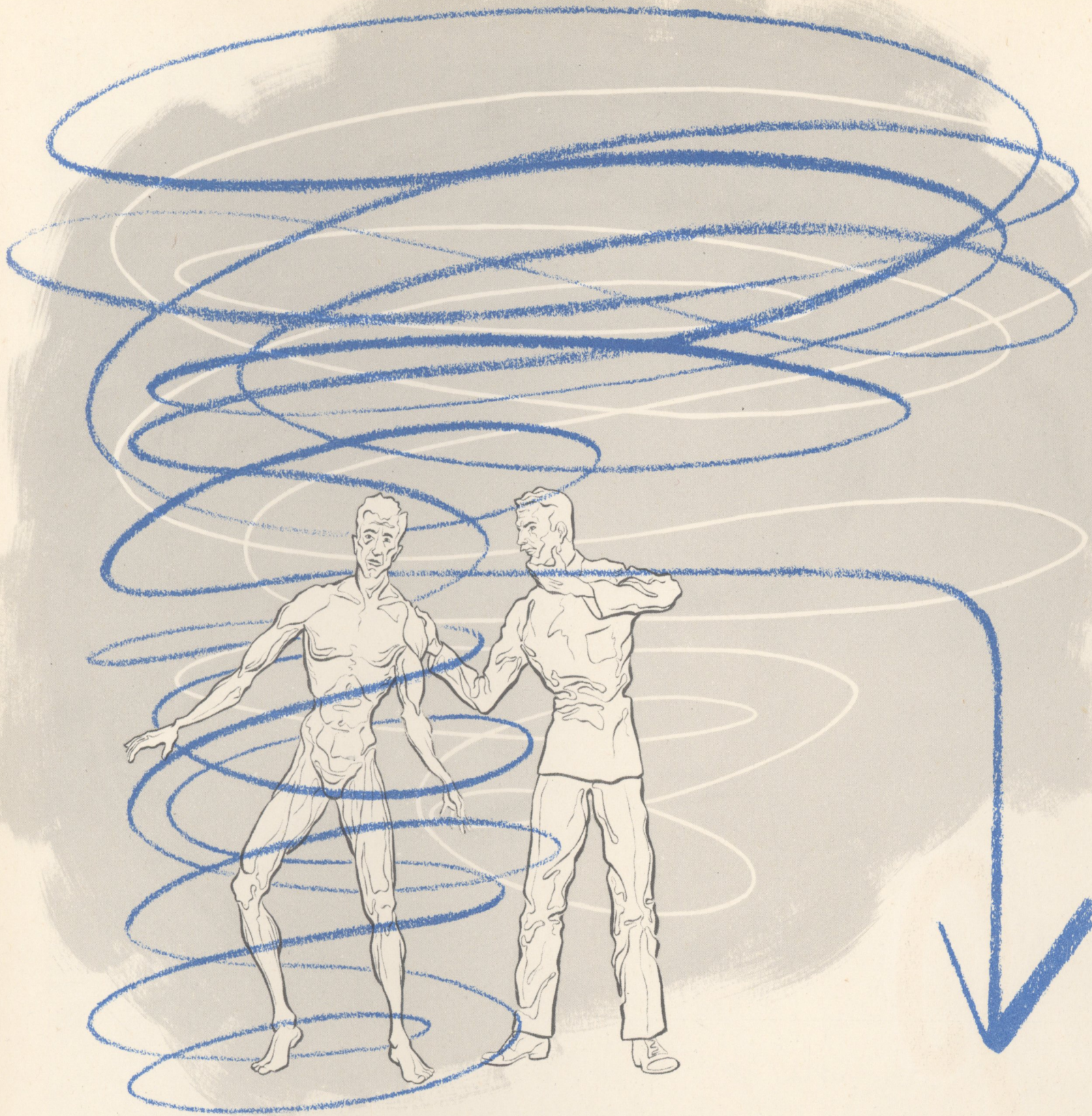
Goodenough, F. L., and Leahy, A. M.: *The Effect of Certain Family Relationships Upon the Development of Personality*, *J. Genet. Psychol.* 34:45 (March) 1927.

Kanner, L.: *Child Psychiatry*, Springfield, Illinois, Charles C Thomas, 1948, p. 156.

Shirley, H. F.: *Psychiatry for the Pediatrician*, New York, The Commonwealth Fund, 1948, pp. 304, 326.

Symonds, P. M.: *The Psychology of Parent-Child Relationships*, New York, D. Appleton-Century Company, 1939, chap. 5.

Weiss, E., and English, O. S.: *Psychosomatic Medicine*, Philadelphia, W. B. Saunders Company, 1943, p. 610.



A LITTLE INTERPRETATION can go a long way in psychotherapy—sometimes too far. The physician may often be tempted to interpret a patient's feelings—especially if he has learned through reading, lectures, or his own experience, something new about the psychodynamics of personality. In the enthusiasm of such new knowledge the physician may relax some of the caution he has learned to observe in interpreting symptoms to patients. The patient also can become over enthusiastic when he learns something new about himself. This can sometimes lead both the physician and the patient to hurried, unfounded conclusions about the personality and the part it plays in illness. An ounce of interpretation to a pound of listening is a good therapeutic maxim for any practicing physician.

MANY INVESTIGATORS estimate that over half of all patients treated by the practicing physician are suffering from complaints due to emotional disorders.

